

Now as to the conclusion of my case. The pustules, indurations, and other signs, and the history of the case, inclined me to believe it to be one of parasitic sycosis.

At my last visit, I requested the patient to send me a couple of hairs from his beard. He wrote to me as follows:—"I had laid by two of the hairs as requested, but found to-day one of them was lost. It was too painful to attempt at the time to pull out any more; and I fear nothing can be gleaned from the one left, as it is quite dried up. I am now pretty much recovered, and expect in a few days to be all right again."

I examined this hair under the microscope, comparing it with the plates of *Microsporon Mentagrophytes* in Neligan's Atlas, the drawings of which, I may add, were made by Dr. Steele from a microscopic examination of a hair belonging to a patient of Dr. Neligan. I could not arrive at any satisfactory result, and having availed myself of the skilled assistance of Dr. Hewitt, of York-street, who kindly examined the hair for me, and allowed me to examine it with him, I ascertained his opinion, which was this:—"The hair was surrounded at the base by altered epithelium, and decomposed follicular secretion. There was not any evidence of the microsporon mentagrophytes." This being so, these two opinions were open to me:—1. Assuming, with Hardy, and some others, that sycosis is *necessarily* parasitic, to think that the case may have been one of sycosis, for the reason assigned by Dr. Fox (*vide supra*); or, assuming with Hebra and others, that the disease is only *accidentally* parasitic, to think that this was a non-parasitic case of true sycosis. 2. To look on it as a case of impetigo sycosiformis. I confess, I incline to the latter opinion, while I readily admit that much can be said for the former.

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ART. XVII.—*A Case of Operation for Cleft Palate on a Child, aged Five Years, with Success.* By F. A. PURCELL, M.D., M.R.C.S.; Physician to the Cork Fever Hospital, and Secretary of the Cork Medical Society.

JOHN CONNELL, aged five years, a fine, large, muscular child, the youngest of seven, five of whom died, which makes the parents most anxious about this one; on attempting to talk, he mumbles his words, unable to articulate, and can only be understood by his

parents. The soft palate is cleft from top to bottom, exactly in its mesial line, the mucous membrane is continuous over the hard palate, the edges of which are not in perfect apposition, a slight fissure existing in the bone, but only apparent to the touch; the gap in the soft palate observed when the mouth is opened being lozenge shaped, the sides at the centre of the fissure retract into the fauces on each side, and if the child cried, the portions of the palate become drawn so much to each side, as to present no palate whatever, here showing the action of the tensor palati and pharyngei muscles.

I determined to operate; accordingly, on Wednesday, July 18th, 1866, with the kind assistance of Drs. Johnston, Shinkwin, and N. J. Hobart, all of whom agreed that the case was a fair one for operation, we proceeded to work in my study; our patient, wonderfully strong, was anything but quiet, and determined to give every resistance. He was well secured by encircling legs, arms, and body firmly in sheets, and placed sitting on a chair; we allowed the father to be present, to exert his influence over him; a pillow lay across the back of the chair, on which the head was firmly held by Dr. Shinkwin from behind. I sat on a chair opposite him, with my back to the light; during the operation the head was turned to one side or the other, as required, so as to get as much light as possible on the part; the mouth was held open by means of one cork, with a fold or two of linen to prevent its being cut through by the teeth; the cork was long, so as to give a purchase, and I may here observe, as we only used one cork, that it was changed to one side or the other of the mouth, generally to the side opposite to the one operated on throughout. I used a long forceps, half an inch of the end curved nearly at right angles, having claw tops, the rest straight; with this I secured the left uvula, and passed at its base from before backwards, the needle armed with a silk ligature; this needle was curved, and the eye was two-fifths of an inch from the point, which I shall refer to again; all my ligatures were cut a yard long and waxed; the point of the needle brought to view posteriorly, one thread was seized with the forceps, and drawn out of the mouth, the needle then withdrawn over the other end, the two ends of the ligature were knotted; this I call the tension ligature (an improvement due to one of our Dublin surgeons, Mr. L'Estrange), the same was passed at the base of the right uvula; the left palate was now put on the stretch by pulling its tension ligature with the left hand to the right side of the mouth,

and determining with my index finger the position of the hamular process, I transfixed the palate perpendicularly and close to the hamular process from before backwards, according to Pollock's plan, using his spear-pointed double-edged knife, which is by the curve of its shank beautifully adapted for the division of the tensor palati muscle; passing the knife a little upwards and inwards, elevating then the hand, so as to cut the posterior fibres, I withdrew it; some oozing of blood followed; the palate became relaxed, thereby showing the muscle was cut. Our patient was now allowed breathing time. The right palate was made tense in the same way, and the knife this time in the left hand, transfixed and cut the tensor palati of that side; considerable oozing of florid blood here followed, which made me anxious for the moment, but it soon stopped; we now found by gently drawing on the tension ligatures of both sides that the edges of the fissure came nicely in apposition, thereby not requiring the division of the palatopharyngeal muscles; this completed the first part of the operation. The second part—the paring of the edges—was long and tedious; using still Pollock's knife; the movement of the tongue being quite uncontrollable, the constant crying, and the exertions that each of my assistants were put to to keep the child still, and to keep the mouth open, were quite sufficient to impress each with the difficulty of operating on a child so young. The paring finished and time allowed for all oozing to cease, as also for my assistants to recover, we proceeded to the third stage—that of passing the ligatures; the mouth opened, and the fauces well mopped out, making tense the left palate by traction of its tension ligature, the needle armed, was passed close up to the edge of the hard palate from before backwards, and pushed on until the eye with the threads came to view, one of which was seized hold of with the forceps and drawn through and out of the mouth, the needle then withdrawn over the other end, the same as the tension ligatures were passed before; this then was our first single ligature passed only on the one side of the fissure. On the right side, and directly opposite the other, the needle armed was passed, the eye coming to view with the thread, the entire noose was seized with the forceps and drawn forward and placed over my little finger, the needle then withdrawn; into this noose the posterior thread of the single ligature of the opposite side was passed, and this noose, acting as an eye, drew the single ligature through the right side from behind forwards. The ligature was now drawn from side to side, to test

its proper insertion. I forgot to state that a knot was placed on the anterior thread of the ligature when it was passed through the left side, so as to mark the anterior from the posterior; as also, one knot indicated ligature No. 1, two knots on the second indicated ligature No. 2, ditto No. 3. Knots to correspond were placed on the other end of the ligatures when drawn through the right side. Ligature No. 2 was passed in the same way, about half an inch or less below the first; the child, by its exertions, defeated me in passing No. 3 through the sides of the uvula; the part being flaccid and giving way before the point of the needle, we determined not to mind it. I here removed the tension ligatures, and proceeded to tie the others. The way the ligatures were tied was by placing a slip knot of one thread over the other and running it down, but not too tight; this brought the edges of the fissure together, and over the slip knot was placed a simple knot, which quite secured the knots from giving; the edges of the fissure were in nice apposition, and the child now swallowed some sops of water and articulated clearly and distinctly, much to the gratification of its father. The exertion of the child did in no wise exhaust it; but my three assistants, to whom I can never return sufficient thanks, were completely done up. My little patient was allowed to go home, with directions to keep him quiet, to get nothing but drinks, with no solid food.

Thursday morning, 19th.—Slept well during the night; edges of the fissure in apposition, parts inflamed and œdematous; child talks fluently; the lower portion of uvula lies in apposition, but apparently not united.

Thursday evening.—Dr. Johnston saw the child this evening; he notices an islet hole at the apex, directly under the edge of the hard palate; the rest in apposition, except portion of the uvula, which will evidently not unite; tongue furred. Gave gr. iii. of calomel; to take a teaspoonful of castor oil in the morning.

Friday, 30th.—Child improved; craving food; the edges not united above at the apex for about the one-eighth of an inch; between the ligatures perfect adhesion; the uvula free.

The parts gradually got well, and I removed, on Sunday morning, the ligatures with rather some difficulty. The weather was very warm, and the child was allowed to drink freely of cold iced water. I determined not in any way to interfere with the ununited portions for the present. He talks fluently and distinctly. The operation is so far successful that I am sanguine

of making a perfect palate. The uvula portion has greatly shrivelled up, and if allowed to remain as it is, would not be bad. The hole at the apex admits freely the end of a drawing lead-pencil; this will, I have no doubt, close by the use of the nitrate of silver stick.

The case suggests many things to me—firstly, I quite agree with Mr. Pollock, that under fifteen years of age I would not operate, unless compelled so to do, as no one can imagine the labour to overcome the struggles of this child; and with any other assistants but those I had, I should have desisted. In a child the tongue is for ever in motion and in the way, and an assistant's hand while using a depressor is completely so; the movement of the tongue causes great delay in manipulating the instruments. Pollock's knife is admirable, but I would like two, one the present size, and the other with a narrow blade; the forceps I used could not be worse; one with a gentle curve of the blades, with a slide like Charrierès to close them, would be preferable, and would hold the mucous surface of the edges. My needle had the eye two-fifths of an inch from its point; the difficulty was in trying to bring the eye to view; the point was apt to stick either into the back or sides of the pharynx, and required great care; the eye then should be as near the point as possible, and the needle fine. It is doubtful to my mind but that silver wire is preferable to silk, except in a child; at all events the two upper ligatures might be silver, and the lower one silk, which may be less in danger of irritating the epiglottis. There is little danger of the sutures passing backwards.

Some improvement might be suggested for keeping the jaws apart—as a cork, such as I used, is rather clumsy.